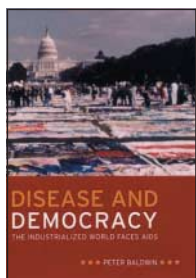


reviews

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Disease and Democracy: The Industrialised World Faces AIDS

Peter Baldwin



University of California Press,
£29.95/\$44.95, pp 478
ISBN 0 520 24350 1
www.ucpress.edu

Rating: ★★★

Historians are calling Hurricane Katrina—which hit the US Gulf coast and the Louisiana city of New Orleans at the end of August—one of the most devastating natural disasters in American history. In its immediate aftermath, the mayor of New Orleans, fearful that prolonged flooding and contaminated water would lead to dehydration, food poisoning, and the spread of hepatitis A, cholera, and typhoid fever, issued a mandatory evacuation order. Those who failed to leave the city voluntarily might be forced to leave. Local, state, and national authorities have since been blamed for failures to respond effectively.

In Katrina's wake, Peter Baldwin's *Disease and Democracy* strikes a resonant chord. Baldwin analyses differing approaches to the AIDS epidemic among industrialised countries. He argues that the divergence in AIDS strategies in the US, Britain, Sweden, Germany, and France is path dependent—predetermined by earlier 19th century efforts against other epidemic diseases, such as cholera and syphilis. He argues that “traditional political analysis of the response to the epidemic is inadequate. Left and right, conservative and liberal, are not labels that help explain why administrations and nations adopted their approaches to the epidemic. Such decisions were taken in accord with deeper, prepolitical policy structures already set in place during the previous century.”

In particular, Baldwin emphasises historical societal preferences established in the 19th century on either side of the line dividing consensual, voluntarist strategies (education, counselling, and voluntary behavioural change) from “harsh” public health interventions focused on quarantine, compulsory institutionalisation, and forcible

treatment. This division represents the age old conflict between individual liberties and the collective good.

Inarguably, the concept of path dependence helps us analyse responses to disease epidemics, natural disasters, and broader health policy developments. A prime example is the United States employer related health insurance system—still intact, despite much criticism, owing partially to a labour-management compromise earlier in the 20th century. History does matter as an enduring influence and helps us understand contemporary policy and practice.

At the same time, however, no analysis of institutional memories is complete without a more in-depth examination of underlying norms and values embedded in those institutions. The moral templates and values of organisations, interest groups, political parties, and individuals prompt them to take certain positions and advocate key agendas, which in turn shape societal decision making. Baldwin's use of historical institutionalism—his book's primary analytical framework—is helpful in highlighting history's contingencies and the persistence of precedents and path dependency. But while he emphasises a conflict between individual liberty and the collective good, his framework neglects more fundamental norms of justice, fairness, redistribution, and human behaviour.

Understanding a culture's respect for human dignity and agency is essential to any analysis of HIV and AIDS. Analysing responses to HIV/AIDS from the perspective of norms and values over time, for example, would reveal significant intellectual and moral transformation and reform. It would show changes in cultural views of

morality, class, race, and inequality. Norms about lifestyles of those initially most vulnerable to HIV transmission—gay men, prostitutes, and injecting drug users—are of particular interest, as are the presence and persistence of health disparities among vulnerable populations.

A normative framework would help us discover whether responses such as victim blaming are less prevalent now than previously. It would reveal the values that underlie or precipitate a “voluntarist” approach (respect for human agency and autonomy) as opposed to a “harsh public health” approach (centralised social engineering). Analysis of these underlying values might demonstrate that countries' policies and practices fit less neatly into one of these two overarching strategies.

Such is the case with the American response to Hurricane Katrina, which represents both harsh public health and voluntarist realities (see p 916). Looking more deeply at the Louisiana example, one finds a public health fiasco whose national policy response reflects lack of consensus on many key public health values—equity, efficiency, compassion, altruism, autonomy, security, safety, and choice. Americans' and Louisianans' views on race and class have significantly influenced the region's disaster preparedness. Contrary to Baldwin's analysis, an examination of Katrina does expose political ideology embedded in public policy—in this case conservative public policy toward poor African-Americans. It reveals a built-in bias manifested in disparities in wealth, access to transportation, and overall ability to respond to disaster. This bias represents not only path dependence but more recent shifts towards conservative ideology, for example in housing policy in New Orleans over the past several decades and Bush administration values. The failure to respond effectively is rooted not just in history as much as in current circumstances and administration views of public health, security, poverty, and race.

Hurricane Katrina has taught us that US government policy can result in the unnecessary loss of hundreds of lives. The American response to this disaster has been an affront to social justice—a failure to respect the human dignity of all people. That it happened in the year 2005 might have something to do with history, but equally likely it tells us about who we are today.

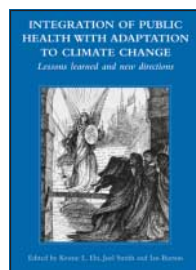
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Should we blame politics or history for the public health fiasco after Katrina?

Integration of Public Health with Adaptation to Climate Change: Lessons Learned and New Directions

Kristie L Ebi, Joel B Smith, Ian Burton



Taylor and Francis, £69, pp 320
ISBN 90 5809 686 6

Rating: ★★★

The global climate is changing, and faster than ever before. The burning of fossil fuels is adding alarmingly to the levels of carbon dioxide in the atmosphere, which acts as a radiation blanket causing average global temperature to rise and changing the world's climate. We can reasonably expect more droughts, floods, extreme weather events, and for the sea level to rise.

All of these will have significant impacts on human health. Indeed, the World Health Organization has estimated that more than

150 000 people in developing countries are already dying each year from the effects of climate change.

Without immediate and dramatic reductions in global carbon dioxide emissions things will almost certainly get worse. And since there is no evidence that any such measures are in hand we should be relieved to learn from this book that public health professionals are teaming up with climate scientists to find better ways to deal with the anarchy that is about to be unleashed on us by our ever more angry atmosphere. We should feel comforted that early warning systems will be set up to detect new epidemics of vector borne infections, that there are plans to take children and elderly people—who are the most vulnerable to heat stress—to special air conditioned cooling centres so that they can survive heat waves, and that emergency workers will know what to do should a river of mud come smashing through a village.

Integration of Public Health with Adaptation to Climate Change challenges us with some seriously unsettling realities, however. It examines a diverse selection of public health case studies to see what lessons can be learnt for adapting to climate change. And it highlights the need to strengthen our decrepit public health infrastructure along with the need to place human health within a broader ecological context. The role of poverty in creating

vulnerability to climate change impacts is well recognised. High income, energy profligate countries are responsible for most greenhouse gas emissions but those living in low income, energy thrifty countries will suffer most of the adverse health impacts.

This book was written before Hurricane Katrina ravaged the southern seaboard of the world's most carbon hungry nation and, although the links between hurricane activity and global warming are uncertain, it is nevertheless remarkably prescient. After having been besieged by media images of bloated black bodies decomposing in the toxic swamp that has replaced large parts of New Orleans, President George W Bush, speaking from a church pulpit in Washington, said, "As we clear away the debris of a hurricane, let us also clear away the legacy of inequality."

This time our planet was teaching a lesson about equity that even the architects of North America's economic apartheid appear to have understood. As global temperatures rise there will be many more lessons on the relation between our economy and our ecology.

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Panorama: Love Hurts

BBC 1, 16 October at 10 15 pm

Rating: ★★★

In the past 10 years sexually transmitted infections (STIs) almost vanished from public consciousness in the United Kingdom. After fairly successful campaigns in the 1980s the problem of STIs seemed, mistakenly, to have been banished. For at a time when more sexual partners and risks at a much earlier age are common practice, UK genitourinary medicine clinics are struggling to meet demand.

Panorama began its report about STIs with an early morning visit to a small clinic in Sheffield, where the phones were ringing without interruption and where the receptionist's standard reply to callers was "Earliest in a month" or even "No appointments at all can be made at the moment." This clinic sees more than 1500 patients a month.

Cut to a "girls' night" in the local strip club, typical of the uninhibited nightlife in which many youngsters seem to indulge most weekends. Among the group of revellers featured was 24 year old Sian, who had been diagnosed as having chlamydia and has been trying to get pregnant for more than two years.

Reporter Andy Davies' documentary juxtaposed footage from the overloaded genitourinary medicine clinic, where huge numbers of positive test results were being analysed every day and where the workload had doubled in the past decade, with interviews with young, sexually active adults. "After a boring week of work, being at the same time exposed to sex in the media all the time, the only thing to look forward to on the weekend is to get completely drunk and then having sex with whoever is available," admitted one young clubber. With attitudes like this, missing condoms provided no obstacle to intercourse.

The numbers speak for themselves: 1 in 10 under 25s is infected with *Chlamydia*, but only one in three realise that they are infected. Compared with a decade ago, there are twice as many new cases of gonorrhoea, three times as many new cases of HIV infection and chlamydia, and 16 times as many cases of syphilis being recorded.

Long waits for appointments are making matters worse. A survey conducted by the *Panorama* team revealed that only a quarter of the UK's genitourinary medicine clinics were able to offer an appointment within the recommended 48 hours. Each treatment delay could have serious consequences, such as an increased risk of complications and of passing on infections, as well as a higher susceptibility to HIV.

The thrust of this documentary seemed clear: the government urgently needed to



Sexual health clinics are struggling to meet demand

get its message across. This autumn £130m (\$227m; €190m) was due to be spent reducing waiting times at clinics, to be followed by a £15m safer sex campaign next spring. A chlamydia screening programme for all 16 to 24 year olds is also expected to start soon.

But for many, like Sian, it is already too late: at the end of the programme she found out, after laparoscopy, that like about 100 other young women in Sheffield every year she would now never be able to get pregnant naturally and that her only option would be in vitro fertilisation.

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PERSONAL VIEWS

The future of tobacco

Tobacco is a perpetually controversial topic. It causes millions of deaths every year and will continue to do so as addiction to nicotine spreads in developing countries in the most popular form of its delivery, the cigarette.

The history of the public health war against tobacco is filled with victories and losses. Many of the victories, such as advertising bans, have been pyrrhic, in that restrictions that fall short of full eradication have been circumvented, and successful marketing has continued through means that are uncontrolled by national parliaments—Formula One motor racing is a good example. Attempts to regulate tobacco as a drug have failed in the United States and have not been seriously attempted elsewhere, although the European Union has some limited restrictions on tar, nicotine, and carbon monoxide. Canada requires disclosure of the constituents of smoke but applies no restrictive regulations.

The decline in the prevalence of smoking is depressingly slow. The smokable forms of the drug are still used by between a quarter and a half of adults in most countries, and use is increasing among women. Although not well quantified, consumption of other forms of tobacco, such as chewing, are widespread in India and elsewhere in Asia.

Global consumption of tobacco is falling slowly at present, but the amount consumed remains at more than 5 million tonnes a year. The driving force behind this massive consumption is, of course, nicotine addiction—even if the effectiveness of nicotine delivery varies greatly with mode of use, the chemistry of the product, and the nicotine requirements of the user (which may also vary greatly). The power of the drug is shown by the fact that a serious national attempt to help UK smokers quit produced an abstinence rate after 12 months of only 15% (*Addiction* 2005;100:84-91).

With a global picture like this it is difficult to see tobacco going out of fashion, and existing antismoking policies have not solved the problem, even if such places as California have come relatively close, with the application of sensible policies and large resources by public health standards.

Two alternative approaches exist. One is prohibition of tobacco. The literature of

tobacco control does not regard prohibition as a serious or sensible policy, probably because of the experience with the attempt to prohibit alcohol in the United States in the 1920s, which merely sent the drug underground and facilitated the rise of a new class of criminal.

The second alternative is to find other nicotine delivery systems to compete with tobacco—a policy that would, reasonably, be developed in parallel with increased restriction (but not prohibition) of sales of tobacco. Alternative nicotine delivery systems exist in the form of nicotine replacement therapy and variations of cigarette like devices that deliver lower levels of some toxicants (which have yet to succeed in the marketplace). Nicotine replacement therapy is neither as addictive nor as widely available as tobacco. Without changes to both of these characteristics it is unlikely to compete effectively with tobacco.

If prohibition is ruled out, then the development of competitor products is a logical way forward. This would require a huge change in attitude among various constituencies. The tobacco control lobby has not embraced the concept in any united way, and many among its ranks find it extremely difficult to condone any form of continuing addiction. Others among them think that

existing tobacco control policies will prevail over time and are more likely to do so if seriously large resources are applied. Promoting the idea in parliament of more effective (and therefore presumably addictive) non-tobacco nicotine products, to be marketed freely, is also not a surefire way to political acclaim. Regulators, who are usually subject to political direction, are unused to encouraging or facilitating development of more addictive sources of clean nicotine—and moreover have no current mandate to do so. Finally, the pharmaceutical industry would need to develop these products, and these companies would surely need encouragement and guarantees of access to the market.

The question of whether such a policy would increase or decrease rates of quitting is complex and the answer speculative. An effective competitor for tobacco would probably increase quitting among people who are resolved on quitting but might serve as a bridging source of nicotine among non-quitters when smoking is forbidden, as in many workplaces.

Therapeutic nicotine has been found safe for short term use (Neal L Benowitz (ed), *Nicotine Safety and Toxicity*), but long term use has not really occurred so has not

been studied adequately. However, any risks ought to be minuscule when compared with those associated with tobacco.

So, tobacco will prevail as the world's major source of nicotine, unless some key establishments change their attitudes. Given that we now have a large tobacco control community with substantial skills and resources, it is a pity that a more coherent leadership in global policy has not been developed. The question of freely available, addictive non-tobacco nicotine products needs to be resolved. Otherwise we leave the field open to tobacco and to an unregulated tobacco industry whose history in relation to lower risk products is profoundly discouraging and whose product is a continuing disaster.

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The development of competitor products is a logical way forward

Hit parade

bmj.com

These articles scored the most hits on the BMJ's website in their first week of publication

SEPTEMBER

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7042 hits
- Editorial: Which career first?**
BMJ 2005;331:588-9
6229 hits
- Editor's choice: A time to die**
BMJ 2005;331 (24 September)
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- Editorial: Foundation programme for newly qualified doctors**
BMJ 2005;331:465-6
5865 hits
- Filler: Chocolate poisoning**
BMJ 2005;331:633
4886 hits
- News: Senior doctors admit mistakes in campaign for more open culture**
BMJ 2005;331:595
4548 hits
- Clinical review: Scabies: diagnosis and treatment**
BMJ 2005;331:619-22
4521 hits
- Editorial: SSRIs and gastrointestinal bleeding**
BMJ 2005;331:529-30
3975 hits
- Letter: Junior doctors' shifts and sleep deprivation: new on-call rotas do not work**
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BMJ 2005;331 (17 September)
3772 hits

All articles cited are full text versions.

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See *News* p 925

Informed consent (and a flutter in Vegas)

I need your consent for this. Now as you know, even after transoesophageal echocardiography, there's still a small risk of stroke."

Stroke. That word seemed louder than the rest. She carried on talking, but I heard nothing else. Stroke? I had to be strong for my wife (and she was feeling just the same towards me). So there we were, being silently strong together.

Let me backtrack. A short trip to Las Vegas had been unexpectedly complicated by an immediate flurry of ectopic beats after I had rapidly drunk an ice cold beer. Now, that's not unusual. I get ectopics most nights if I lie on my right side (although the left side is fine—I have never been able to work that out). But ectopics after a cold drink? This was new. The ectopics persisted throughout the day, uncomfortable and irritating. Then, that night, I awoke with a start. Something was wrong. I clutched at my carotid pulse. I was in atrial fibrillation. But how could this be? I'm young and extremely fit, with a resting heart rate of 35.

I must have drifted back to sleep. Awakening before dawn I felt better. Had it been a bad dream? My pulse was slower and more regular—or was that just wishful thinking? So I did what all good athletic doctors do: I went for a run. There was some logic behind this. If I could overpace the ectopics, maybe I would settle back into sinus rhythm? Running along Las Vegas Strip was a joy. If you haven't already guessed, I'm a runner. Running is my life; medicine is just a hobby. It felt good to be out there in familiar territory—just the road and me. I ran steadily for a couple of miles. ABC? Airway fine. Breathing easy. Circulation? I checked my carotid pulse—210. Regular or irregular? It was just too fast to tell. Maybe this cunning plan was not so cunning after all. I turned around and ran back to the hotel.

And so it continued for three days, despite some carotid sinus massage and Valsalva manoeuvres. We flew home. I thought about heading into work, but I had the day off, so why waste it? Second time lucky, I thought. Another run will sort me out, and it did. Although the run itself passed without incident, about an hour later things changed. My chest suddenly felt tighter. My heart was really pounding. Pulse rate? Exactly 150. This could mean only one thing: atrial flutter with a 2:1 block. This was quite distressing. I needed help. Day off or no day off I had to go in. Still, at least I can still diagnose flutter.

After two doses of enoxaparin and bisoprolol, and one day later, I was ready for

transoesophageal echocardiography and elective cardioversion, assuming the atria were clear. This is how we ended up at the informed consent process.

"Now as you know..."

Lying on that bed, however, I didn't know. I couldn't remember. At that moment I wasn't a consultant gastroenterologist; I was Joe Public, and I was scared.

Stroke? I didn't want to hear figures or percentages. I wanted to be told it wasn't going to happen. I know there can never be guarantees, but at that moment what I

needed was reassurance. As an example of what I mean, take Ed Harris's character (Gene Kranz, head of the Houston Control Centre) in the film *Apollo 13*. Everyone knew there was a chance the astronauts could (and probably would) die, but verbalising this would not have helped anyone. Instead they heard this: "We've never lost an American in

space; we're sure as hell not going to lose one on my watch. Failure is not an option."

"Informed consent." What's that all about then? Are we really doing the best for our patients by quoting them risks, figures, and percentages? Precisely whom are we treating when we do this? Just because we dish out this information, we feel we've done our job and our conscience is clear. I'm not talking about elective procedures here but rather any acute procedures when the only realistic choice is to proceed. Look at it from the patient's perspective: right before the start of the procedure (whatever it may be) you're dished up a list of potentially awful consequences that consume you with fear and helplessness. And for what? Does it really benefit the patients? I suggest not. Would some paternalistic "not on my watch" reassurance really be so bad? Maybe we should ascertain just what information our patients want before scaring them half to death with informed consent? Others may disagree, but from my personal experience I would rate reassurance above percentages any day.

Postscript: I use local anaesthetic throat spray alone in more than 80% of upper gastrointestinal endoscopies. I've always told my patients I would choose spray over sedation. So I thought I should stick to my guns and do the same for the echocardiography. Now there was an interesting experience—but that's another story.

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Should we ascertain just what information our patients want before scaring them with informed consent?

SOUNDINGS

Beans

Anatomy books often describe the kidneys as bean shaped, but the converse does not apply. This is because beans, multitudinous in their species, come in many different sizes and shapes. Many beans indeed look like small kidneys, but only one, the red bean, bears the name of kidney beans.

Pythagoras advised his pupils to abstain from beans, possibly to avoid the consequences of favism from G6PD (glucose-6-phosphate dehydrogenase) deficiency, which is common along the Mediterranean littoral. But some think it was advice to stay out of politics, because politicians used beans to register their vote. Such ambiguity has also applied to Chicago's reputation as the Windy City, generally believed to reflect the cruel winds that blow over the city in the winter. But some think it is because of the city's long winded politicians.

Accountants are often referred to as bean counters, as are administrators who cannot see beyond their spreadsheets. But bean counters can also be found among licensed medical practitioners, especially among those who like to tell others how to practise medicine rather than do it themselves.

Beans, red or otherwise, constitute the staple diet of vegetarians. They are high in protein (1 cup = about 16 g), unsaturated fats, fibre, vitamins, and minerals, and low in cholesterol. They are deemed to be good for diabetes, hypercholesterolaemia, constipation, and preventing colon cancer. A certain legendary prince is supposed to have deflowered numerous virgins in a single night while taking no nourishment other than chick peas. This suggests that beans may be a source of unusual vigour, as well as filling one with wind.

Humans cannot break down the oligosaccharides originating from beans because they lack the enzyme α galactosidase. Instead they break them down to hydrogen, carbon dioxide, and certain malodorous gases. Attempts to produce a "low flatulence" bean have been unsuccessful, as have manoeuvres such as soaking them in water to leach out oligosaccharides. Flatulence has long been the subject of reviews, including Dr Michael Levitt's reference to the occasionally dramatic explosion occurring during electrocautery of the colon, when the ratio of methane to hydrogen reaches the incendiary range and causes a frightening blast (*NEJM* 1980;302:1474).

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